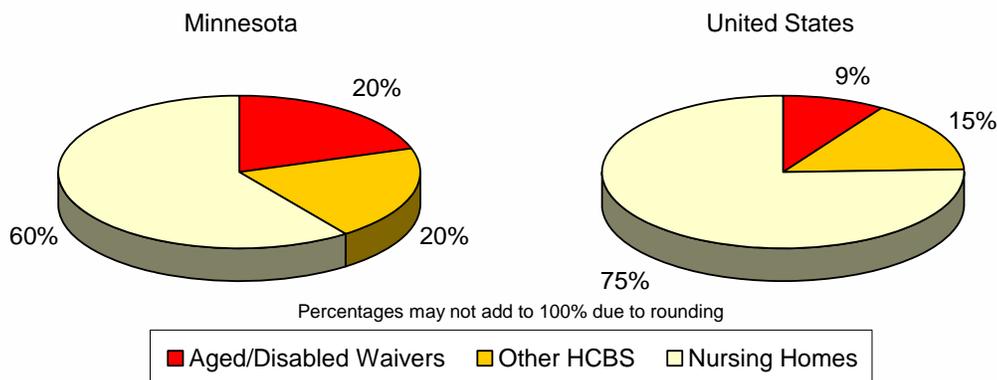


State Long-Term Care Reform in
MINNESOTA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Minnesota and the U.S., 2006



Compared to the U.S. average, Minnesota allocates a greater percentage (40%) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to home and community-based services (HCBS). In FY 2006, Minnesota spent 20 percent on waiver services and 20 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	18,574	34,385	+15,811	\$209	\$566	+\$358
Nursing Homes	38,925	39,016	+91	\$901	\$853	-\$48

Minnesota has made significant progress toward achieving a balanced LTC system for older people and adults with physical disabilities, and recent Medicaid trends indicate a large increase in HCBS participants and expenditures and a decrease in nursing home expenditures. While the number of participants receiving HCBS increased significantly from 1999 to 2004, the number of participants receiving nursing home care remained relatively constant. Spending on HCBS more than doubled between FY 2001 and FY 2006, while spending on nursing homes decreased. Participant and expenditure data are underreported here because they do not include Medicaid managed care programs.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report *A Balancing Act: State Long-Term Care Reform (#2008-10)*.

Medicaid is not the only source of funding for LTC. The Alternative Care Program is a state-funded, cost-sharing program that supports certain home and community services for Minnesotans age 65 and older. In FY 2007, the program served 5,158 people, with total expenditures of \$25.7 million. Services include adult day, case management, chore, companion, home-delivered meals, homemaker, personal care, respite, and support for family caregivers.

Major Initiative

Minnesota expanded coverage in recent years for its managed care programs, which include LTC services for older persons. Medicaid beneficiaries age 65 and older are required to enroll in Medicaid managed care. Managed care plans in all counties (four additional counties were to be added in March 2008) provide additional services, such as transportation, interpreter services, and case management beyond what is typically included in fee-for-service.

“Minnesota Managed Long-Term Care”

Minnesota expanded its managed care programs through the Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+).

Launched in 1997, Minnesota Senior Health Options (MSHO) provides services to people age 65 and older who are dually eligible for Medicare and Medicaid or who have Medicaid only. MSHO plans provide Medicare services such as Part D drugs as well as health care and LTC services. Enrollment is voluntary.

Minnesota Senior Care (MSC) and Minnesota Senior Care Plus (MSC+), launched in June 2005, also provide health care and LTC services, but enrollment is mandatory. MSC+ is similar to MSHO, but it does not cover Medicare services or Medicare Part D drugs. (Beneficiaries must sign up with a separate Medicare prescription drug plan to receive Part D drugs.) The state is phasing out MSC in favor of MSC+.

Other Developments

Nursing Home Bed Reduction. In a two-year period ending in 2005, nursing facility bed supply had declined by 2,348 beds or 6 percent. Several policies contributed to this outcome: 1) a Voluntary Planned Closure Program that provides an adjusted rate increase to nursing facilities that voluntarily close beds; 2) a Bed Layaway Program under which nursing facilities temporarily close beds on a voluntary basis in return for an adjusted reimbursement; and 3) a Single Bed Incentive enacted by the legislature in 2005 to encourage creation of single-bed rooms in combination with bed closures.

If those trends continued, state officials predicted in 2006 that the state would take 14,000 additional beds offline in the next 15 years, resulting in fewer than half the beds the state had at its peak in 1987—48,307 beds.

Long-Term Care Planning. In 2006, Minnesota adopted a “Transform 2010” project to identify the impact of the wave of baby boomers turning 65 in 2010, and to reexamine the state’s health and LTC systems for their ability to serve this population.